DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

	IT OF DEFICIENCIES OF CORRECTION	li '		00	COMP	(X3) DATE SURVEY COMPLETED 05/12/2011	
	PROVIDER OR SUPPLIER		801 N	ADDRESS, CITY, STATE, ZIP CO HUNTINGTON AVENUE EN, IN46792	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F0000	This visit was for Licensure, and St. Survey dates: M 2011 Facility number: Provider number AIM number: 10 Survey team: Kim Davis, RN, Vicki Bickel, RN Donna Smith, RN Tammy Alley, RN Toni Maley, BSV DeAnn Mankle, 15/10, 5/11, and 5 Census bed type: SNF: 14 NF: 54 SNF/NF: 68	a Recertification, State tate Residential Survey. ay 9, 10, 11, and 12, 000542 : 155705 00267380 TC N N V RN 5/12, 2011)	F0000	DEFICIENCY		DATE	
	Residential: 16 Total: 303 Medicare: 14 Medicaid: 63 Other: 226 Total: 303 Sample: 24						
LABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE		(X6) DATE	

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OT6011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A DIFFERENCE 00 COMPLETED					
ANDIEM	or connection	155705	A. BUII			05/12/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				IUNTINGTON AVENUE		
	SE POINTE			WARRE	EN, IN46792		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG	Supplemental Sa	*		IAG			DAIL
	Residential Samp	•					
	Residential Samp	Jic. /					
	These deficiencies cited also reflect state						
	findings in accordance with 410 IAC 16.2.						
		1 . 1 - 1 - 1					
		ompleted 5-17-11					
	Cathy Emswiller	RN					
F0167	A resident has the	right to examine the results					
SS=C of the most recent survey of the facility							
conducted by Federal or State surveyors and							
	• •	tion in effect with respect to					
	the facility.						
	The facility must m	nake the results available					
		nd must post in a place					
	readily accessible a notice of their av	to residents and must post					
		ation and interview, the	F0	167	Please note that there were a	а	05/12/2011
		have the results of the			total of 6 survey books availa		
	•	ey readily available for			in the facility with a sign post the entrance stating the local		
		their review as indicated			of each book. All residents h		
		ents that attended the			been identified as being affect		
	•	# 3, 22, 26, 60, 67, 85,			should they desire to review		
		28, and 134) and for 2 of			survey findings. In addition, t survey book at the reception		
		bserved. This practice			was in fact complete and all	GOGIN	
	-	to impact 137 residents.			books are always updated at	the	
	_				same time. It is likely that	_4	
	Findings include	:			someone pulled the complair survey dated 9/10/10 from the		
					book in the library. The book		
	1. During the en	vironmental tour on			the library was updated again	n on	
	5/11/2011 at 9:40	A.M., with the			5/11/11 and all other survey books were checked to ensu	ıro	
		pervisor, the front lobby			they were up-to-date as well.		
	of the building w	as observed for the			survey books were checked	to	
	survey book. Th	e receptionist was			ensure they were complete a	and	

000542

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155705		LDING	00	05/12/2011
		100700	B. WIN		DDDEGG CITY CTATE ZID CODE	00/12/2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE HUNTINGTON AVENUE	
HERITAC	GE POINTE			1	EN, IN46792	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
IAG		,		TAG	were relocated so that they	DATE will be
	interviewed about the location of the survey book. She indicated the survey				accessible to residents without	I
	book was on the desk behind the her in				having to ask staff for them.	l l
	her office.	desk bennid the her in			signs were posted as to whe	
	ner office.				the location of the survey res can be found. All survey boo	l l
	On 5/11/2011 at	11:45 A.M., with the			will be reviewed monthly for	
		pervisor, a second loose			months then quarterly to ens	ure
					they are up-to-date. Replacements will be put in a	anv
	leave notebook with the survey results was observed on the bottom shelf of the				books found to have missing	-
	newspaper rack i	n the library. The			survey results. Any concern	
	contents of this survey book's last survey posted in the book had a date of				be reported to the QA Comm for review and	nittee
					recommendations.	
	06/04/2010. A co	omplaint survey had been				
	completed on 09/	/10/2010, but the results				
	were not posted i	in the survey book.				
	There was no sig	n posted that indicated				
	the location of th	_				
	During the group	meeting on 05/10/2011				
	at 10:45 A.M., R	esidents #3, #22, #26,				
		117, #120, #121, #127,				
	,	ndicated they did not				
		results of the last survey				
	where located in	the building.				
	During an intervi	iew with the social				
	_	2/11 at 9:30 a.m., she				
		ility had placed the				
		the books last night and				
	-	ole for the residents.				
	3.1-3(b)(1)					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155705	B. WING			05/12/2	011
	n o v v n n o v v n n v v n n		1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			801 N H	IUNTINGTON AVENUE		
	SE POINTE				EN, IN46792		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCI)		DATE
F0248 SS=E	program of activitic accordance with the assessment, the immental, and psych resident. Based on intervice facility failed to pactivities to meet needs and desired interviewed in a # 79, # 26, and # cognitively imparactivity participa (Resident # 12, # had the potential cognitively imparactivity participal interviewed in a potential to affect unable to self initial. Findings include 1. A list of interprovided on 5/10 Social Worker # and # 22 were on During a group in 10:45 a.m., Resident.	ew and record review, the provide weekend individual resident s for 3 of 13 residents group setting. (Resident 22) and for 4 of 4 ired residents review for tion in a sample of 24 if 94, # 59, and 89) and to affect 16 of 16 ired residents and the t all residents who were tiate activities.	F0	248	All healthcare residents on 2. 2B, and 1A were identified to potentially affected. The 1B Healthcare Unit is a Dementi Unit with specialized activitie days per week. Activities succurrent events, music and triviall be incorporated at meal thand added to the weekend at calendar. Residents #79, #26 #22 and other alert and orient residents were given a surver potential activities they would enjoy on weekends. These suggestions will be incorporation the weekend programming. The Activity strivial be required to work more hours on weekends which with include activities for alert and oriented residents as well as residents with dementia that cannot speak for themselves. Interviews will be done with a minimum of 3 residents on 1A, 2A and 2B weekly for 4 weeks then more for 2 months then quarterly to ensure residents are receiving on-going activity programming.	be a s 7 ch as via ime ctivity 6, ated y of d aff e aff	06/01/2011
	She indicated the	ere was bingo on			designed to meet their intere	-	
		C	1	I	_		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
ANDILAN	OF CORRECTION	155705	- 1	LDING	00	05/12/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		1	HUNTINGTON AVENUE		
	GE POINTE			1	EN, IN46792		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
	†	indicated she wanted			and physical, mental and		D.H.E
	more to do but she had not talked to anyone about this. Resident # 22 and # 79				psychosocial well-being. An		
				activity concerns will be reported to the QA Committee for review			
	also indicated there was nothing to do on				and recommendations.	ew	
	the weekends but church and bingo.						
	The April and May 2011 activity calendar						
	was reviewed on 5/10/11 at 1 p.m. The						
	calendar schedule for the weekend was a						
	follows for all the Saturday and Sundays						
	except for May 7, 2011 when there was a						
	Mother's Day party.						
	Saturdays:						
	12 p.m.: Daily (Chronicles					
	2 p.m.: Movie (Channel 63					
	2 p.m.: Bingo						
	8 p.m.: Gaither	Gospel Hour Channel 47					
	Sundays:						
	9:30 a.m.: Chur	rch					
	12 p.m.: Daily						
	2 p.m.: Movie (Channel 63					
	During the week	Monday -Friday, there					
	_	vities scheduled daily,					
		t limited to, sensory club,					
	art expression, s	ing along, sit and stretch,					
	sewing club, coo	oking, bible study,					
	1	games galore, card club,					
	pretty nails, exe	rcise and name that tune.					
	Davious of the	ativity applayed staffing					
	1	ctivity employee staffing on 5/11/11 at 9 a.m.,					
	I nours as worked	on 3/11/11 at 9 a.III.,					

STATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CON	ISTRUCTION		(X3) DATE	SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00		COMPL	ETED
		155705	B. WIN				05/12/2	011
			B. WII		ODRESS, CITY, STAT	E. ZIP CODE		
NAME OF PR	OVIDER OR SUPPLIEF	R		1	UNTINGTON AV			
HERITAGI	E POINTE			1	N, IN46792			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLA	AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE . CROSS-REFERENCED	TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFIC	IENCY)		DATE
	indicated that one activity employee							
	worked on Saturday for approximately 2							
	hours and no act	tivity employee worked on						
	Sundays.							
	,							
	During interview on 5/11/11 at 10 a.m.,							
I .	activity worker # 8 indicated he did not							
I .	•	rs. He indicated Daily						
	-	_						
		a facility newspaper that						
	was given out in the dining room. He							
	indicated the Sunday movie was on							
		ne resident's room and the						
	staff would have	e to turn the TV on for						
	resident's who co	ould not self initiate. He						
	indicated there v	was no activities led by						
	staff on Sundays	5.						
	J							
	During an interv	view with CNA # 9 on						
	•	a.m., she indicated she						
		er weekend. She						
	•	vere no scheduled events						
		except bingo on Saturday.						
		ere were volunteers and						
	family visitors.							
	.							
I .	<u>-</u>	view with CNA # 11 on						
I .		a.m., she indicated she						
	worked on the w	veekends. She indicated						
	there were not ac	ctivities for the residents						
	to attend like thr	ough the week. She						
I		was church on Sunday.						
	She indicated it is very busy through the							
		ities and just not that busy						
	on the weekends	-						
FORM CMS-25	67(02-99) Previous Version	ons Obsolete Event ID:	OT6011	Facility ID	D: 000542	If continuation sl	neet Pa	ae 6 of 28

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155705			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/12/2	ETED	
		155705	B. WIN			03/12/2	011
NAME OF I	PROVIDER OR SUPPLIEF	t .		1	ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	GE POINTE				HUNTINGTON AVENUE EN, IN46792		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	2. The record for reviewed on 5/1	or Resident # 12 was 1/11 at 9:30 a.m.					
	Current diagnoses included, but were not limited to, dementia.						
	A 3/2/11 activity assessment indicated the						
	resident was involved in the following						
	activities: music, hobbies, reading,						
	spiritual, walking/wheeling outdoors,						
	watching TV, movies, talking/conversing,						
	and visits. The a	assessment indicated the					
	resident preferre	d activities in her room,					
	day/activity roor	n and off the unit and					
	enjoyed single o	r group settings.					
	Resident # 12's a	activity attendance record					
	provided by soci	al worker # 6 on 5/11/11					
	at 3 p.m.,for Apr	il and May 2011,					
	indicated the res	ident attended 1 to 4					
	activity events d	aily Monday-Friday					
	which included,	but were not limited to,					
	sensory club, sin	g along, sit and stretch,					
	here's the news,	art club, relaxation					
	station, chapel, n	name that tune, comfort					
	touch, fine art pr	ogram, pretty nails, and					
	movie. The atte	ndance records indicated					
	the resident did 1	not attend any of the					
	weekend events	except the Mother's Day					
	party on May 7,	2011.					
	1	s record was reviewed on					
	5/9/11 at 2:45 p.:	m. The resident					
	_	led, but were not limited					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155705		LDING	NSTRUCTION 00	(X3) DATE : COMPL 05/12/2	ETED	
	PROVIDER OR SUPPLIER	2	 STREET A	ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	SE POINTE		WARRE	EN, IN46792		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	to, dementia and	depression.				
	dated 4/22/11, in awake during the She preferred ac and inside the nu average time in a 2/3 of the time. was a small or la current activities watching televis					
	activity on 4/11, and 26. The resi	ne resident attended 1 12, 13, 18, 19, 21, 25, dent attended 2 activities d 28. No attendance on ere indicated.				
	attended 1 activi	2011, the resident ty on 5/2, 3, 4, and 10 ctivities on 5/5. No e weekend were				
	interview, Social resident did not lishe was able to p	:10 a.m. during an I Worker #6 indicated the have 1 to 1 visits due to participate in activities. Is record was reviewed on				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUII		NSTRUCTION 00		LETED	
		155705	B. WIN			05/12/2	2011
	PROVIDER OR SUPPLIER			801 N H	DDRESS, CITY, STATE, ZIP CODE UNTINGTON AVENUE		
	GE POINTE			WARRE	N, IN46792		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE .	(X5) COMPLETION DATE
	5/9/11 at 11:05 a	.m. The resident's					
	diagnoses includ to, dementia and	ed, but were not limited depression.					
	dated 3/17/11, in awake in the more activities in the daverage time in a the time. The prosmall and large gourrent activities walking/wheel of television, movie and resident visit. The resident's active following: In April, 2011, the activity on 4/11, resident attended 25, and 28. She 4/5 and 4/12. No weekends were in In May, 1 to 10,	tivity calendars indicated the resident attended 1 14, 19, 21, and 26. The 12 activities on 4/7, 13, did refuse an activity on to attendance on the indicated. 2011, the resident thy on 5/2 and 5/3 and ties on 5/5. No					
	On 5/12/11 at 12	:30 p.m. during an Worker #6 indicated the					

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155705 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN B. WING		00	(X3) DATE COMPL	ETED
	PROVIDER OR SUPPLIEF	2	8	01 N H	DDRESS, CITY, STATE, ZIP CODE UNTINGTON AVENUE N, IN46792	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	resident did not	have 1 to 1 visits due to participate in activities.					
5. Resident #89's record was reviewed on 5/11/11. The resident's diagnoses included, but were not limited to, dementia and depression.							
	dated 4/15/11, is awake in the mo activities in her of day/activity room activities was 1/2 preferred group group. The residuals	ctivity Assessment," ndicated the resident was rning. She preferred own room and in the m. Her average time in 3 to 2/3 of the time. The size was a small and large dent's current activities itual/religious activities, evision.					
	The resident's active following:	ctivity calendars indicated					
	activity on 4/5, 1 The resident atte She did refuse at 12, 18, 21, and 2 manicure for the	ne resident attended 1 14, 18, 19, 25, and 29. 20 ended 2 activities on 4/28. 21 n activity on 4/4, 7, 11, 22 n activity on 4/15. No 22 resident on 4/15. No 23 e weekends were					
	an activity on 5/2	2011, the resident refused 2, 3, 5, and 9. No further ndicated on the calendar,					

l	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155705	(X2) MULTIPLE CO A. BUILDING B. WING	00	— сом 05/12	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		801 N F	ADDRESS, CITY, STATE, ZIP CO HUNTINGTON AVENUE EN, IN46792	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	including on the	weekends.				
	3.1-33(c)					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155705	B. WIN			05/12/2	011
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				HUNTINGTON AVENUE		
HERITΔO	SE POINTE				EN, IN46792		
				L	-14, 114-07-32		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F0278 SS=D	resident's status.	nust accurately reflect the					
00-0							
	A registered nurse	must conduct or coordinate					
		with the appropriate					
	participation of hea	alth professionals.					
	A registered nurse	must sign and certify that					
	the assessment is						
		no completes a portion of oust sign and certify the					
		ortion of the assessment.					
		nd Medicaid, an individual					
	•	nowingly certifies a material					
		nt in a resident assessment					
		money penalty of not more ich assessment; or an					
		fully and knowingly causes					
		to certify a material and					
		a resident assessment is					
		noney penalty of not more					
	than \$5,000 for ea	ich assessment.					
	Clinical disagreem	nent does not constitute a					
	material and false						
			F0	278	All residents with highly impa	ired	05/27/2011
	Based on observa	ation, interview, and			vision were identified by revie	•	
		e facility failed to ensure			with the Charge Nurse on ea	ch	
	,	Set Assessment (MDS)			unit to determine if other residents were affected by th	ie	
		ated to a resident's vision			practice. Chart reviews were	13	
		led residents (# 115).			done on all residents with hig	jhly	
	101 1 01 24 841111	icu resiucinis (# 113).			impaired vision to identify an	y	
	Findings Include				potential problems with their	MDS	
	i manigs meidde	•			and care plans. MDS Coordinators will compare ne	ew	
	Resident # 115 was interviewed on 5/9/11 at 1:20 p.m. The resident indicated she	vas interviewed on 5/9/11			MDS's with the previous MDS	S's	
	•				MDS's are accurately done to		
	could only see sr	nadows. She could not			reflect vision impairment. Q	A	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPL	
		155705	B. WIN	NG		05/12/2	U11
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
				1	HUNTINGTON AVENUE		
HERITAG	SE POINTE			WARRE	EN, IN46792		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		to complete her weekly			audits will be completed on I		
	menu. The reside	ent indicated her family			s as they are due for the nex months then quarterly to ens		
	or staff assisted her to make out her meal				the MDS accurately reflects	uic	
	choices.				resident diagnoses. Any		
					problems or concerns will be		
	The clinical reco	rd of Resident # 115 was			reported to the QA Committee		
	reviewed on 5/11	/11 at 8:00 a.m. The			review and recommendation	S.	
	Resident's diagno	oses included, but were					
	not limited to, he						
	Hypothyroidism,						
	i i j potil j i ordisili,	, and Braseles.					
	The Quarterly M	DS dated 1/18/11					
		ident's vision was "highly					
	impaired".	dent's vision was inginy					
	impaned.						
	The Cienificant (Change MDC dated					
	_	Change MDS dated					
		the resident's vision was					
	"adequate".						
		((())					
		ssessment (CAA)					
		3/8/11 did not trigger a					
	vision concern.						
		an related to vision was					
	the Activity care	plan dated 3/8/11.					
	The MDS nurse	was interviewed on					
	5/11/11 at 1:00 p	o.m. The nurse indicated					
	the 3/8/11 MDS	was not accurate.					
	3.1-31(c)(4)						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY
OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	DING	00	COMPL	ETED
	155705				05/12/2	011
		D. WIN		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PROVIDER OR SUPPLIER						
GE POINTE						
		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
`				CROSS-REFERENCED TO THE APPROPRIAT	rE	COMPLETION
REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
assessment to deveresident's compresident's compresident's must do care plan for each measurable object a resident's medic psychosocial need comprehensive as. The care plan must are to be furnished resident's highest mental, and psych required under §44 would otherwise be but are not provide exercise of rights or right to refuse treating to a resident's visual 24 residents care sample of 24 sam. Findings Include Resident # 115 was at 1:30 p.m. The	evelop, review and revise the hensive plan of care. evelop a comprehensive resident that includes tives and timetables to meet al, nursing, and mental and its that are identified in the issessment. St describe the services that it to attain or maintain the practicable physical, inosocial well-being as 83.25; and any services that it e required under §483.25 and due to the resident's funder §483.10, including the itment under §483.10(b)(4). Ever and record review, the ensure a care plan related sion was in place for 1 of plans reviewed in a impled residents (# 115).	F0.	279	vision were identified by reviewith the Charge Nurse on earnit to determine if other residents were affected by the practice. Chart reviews were done on all residents with high impaired vision to identify any potential problems with their and care plans. A new care was written for Resident #115. MDS Coordinators will compare new MDS's with last MDS's to ensure MDS's, CA, and care plans are accurately done to reflect vision impairm QA audits will be completed	ewing ich sis ghly y MDS plan st A's y nent. on	05/27/2011
could only see sh	nadows. She could not					
	PROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OR A facility must use assessment to deversident's comprel The facility must do care plan for each measurable object a resident's medic psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as The care plan	OF CORRECTION IDENTIFICATION NUMBER: 155705 PROVIDER OR SUPPLIER	DENOTICE TO BE TO STATE THE TOP TO STATE	A BUILDING B. WING PROVIDER OR SUPPLIER SEPOINTE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). F0279 Based on interview and record review, the facility failed to ensure a care plan related to a resident's vision was in place for 1 of 24 residents care plans reviewed in a sample of 24 sampled residents (# 115). Findings Include: Resident # 115 was interviewed on 5/9/11 at 1:30 p.m. The resident indicated she	PROVIDER OR SUPPLIER SEPOINTE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under \$483.25 but are not provided due to the resident's exercise of rights under \$483.25 but are not provided due to the resident's exercise of rights under \$483.31.0, including the right to refuse treatment under \$483.10(b)(4). Based on interview and record review, the facility failed to ensure a care plan related to a resident's vision was in place for 1 of 24 residents care plans reviewed in a sample of 24 sampled residents (# 115). Findings Include: Findings Include: Resident # 115 was interviewed on 5/9/11 at 1:30 p.m. The resident indicated she under the provided on the resident's compare new MDS's with las MDS's to ensure MDS's with las MDS	DECORRECTION DESCRIPTION NUMBER: 155705 ROYLDER OR SUPPLIER SEPOINTE SEPOINTE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's medical, nursing, and mental and spychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's medical, nursing, and mental and spychosocial medical physical, mental, and psychosocial and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10, including the right to refuse treatment under §483.10 including the right to refuse treatment under §483.10 including the right to refuse treatment under §483.10 including the right to refuse treatment with right in provided due to the resident's vision was in place for 1 of 24 residents care plans reviewed in a sample of 24 sampled residents (# 115). Findings Include: ROYLDEROR MARKEN, INVARIONE CORRECTION. A MILITARIONE CORRECTION AVENUE WARREN, INVARIONE CORRECTION. A MILITARIONE CORRECTION. A MILITARIONE CORRECTION AVENUE WARREN, INVARIONE CORRECTION. A MILITARIONE CORRECTION AVENUE WARREN, INVARIONE CORRE

000542

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
ANDILAN	or correction	155705	- 1	LDING	00	05/12/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				HUNTINGTON AVENUE		
	SE POINTE				EN, IN46792		
					PROVIDER'S PLAN OF CORRECTION		
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
(X4) ID PREFIX TAG	see well enough to menu. The reside or staff assisted he choices. The clinical reconserviewed on 5/11 Resident's diagnoral not limited to, he hypothyroidism, The Quarterly Mindicated the resisting paired". The Significant C 3/8/11 indicated to "adequate". The Care Area As Summary dated 3 vision concern.	to complete her weekly ent indicated her family her to make out her meal of Resident # 115 was /11 at 8:00 a.m. The oses included, but were eart disease, and diabetes. DS dated 1/18/11 dent's vision was "highly Change MDS dated the resident's vision was sessesment (CAA) 8/8/11 did not trigger a on related to vision was		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ee for	(X5) COMPLETION DATE
	5/11/11 at 1:00 p	was interviewed on o.m. The nurse indicated was not accurate and a					
	vision care plan v	was not in place.					
	3.1-35(a)						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155705		A. BUILDING 00 COM 05/12			E SURVEY PLETED 2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 N HUNTINGTON AVENUE WARREN, IN46792					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F0282 SS=D	facility must be proin accordance with plan of care. Based on observations for review, the aphysician order plate was followed observations for reviewed for eatiful 114). Findings include The clinical recordered included, but were Esophageal Reflet Dementia. The current phys 5/3/11 included a a divider plate.	eng in a sample of 24 (# end of Resident # 114 was 11 at 10:15 a.m. The the resident's diagnoses are not limited to, aux, Anemia, and ician orders signed on an order dated 4/28/11 for dated 4/28/11 indicated,	F0282	The employee respraction received a writer for neglecting job readly residents with or adaptive equipment were reviewed and ensure the orders a followed. An in-service cards and the Importable Setting Accuragiven to all Dietary of May 25, 2011. A locative tray card was added dish. It appears under the diet order of card. QA checks will performed by the Dimensure of the Dimensur	ritten warning esponsibilities. Inders for at meal time checked to be being vice on Tray ortance of acy will be employees on eation on the different for a divided der meal also appears on the tray also pietary Dietary Supervisors 3 weeks at all for 3 months or concerns will DA Committee	05/25/2011		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155705	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COME - 05/12/	LETED		
	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 801 N HUNTINGTON AVENUE WARREN, IN46792					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	between 12:00 p Resident # 114 v regular plate at 1 The breakfast m 5/10/11 between Resident # 114 v gravy on a regul bowl. The breakfast m 5/11/11 between Resident # 114 v breakfast on a re Cook # 16 was i 10:00 a.m. The 114 needed a thr plate because he his food from a re	eal was observed on 8:10 a.m. and 8:30 a.m. was served biscuits and ar plate and hot cereal in a eal was again observed on 8:00 a.m. and 8:30 a.m. was observed eating his gular plate. Interviewed on 5/11/11 at cook indicated Resident # ee compartment divider had difficulty scooping regular plate. The cook ew about the order, but						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DITT	DDIC	00	COMPL	ETED
		155705	A. BUIL B. WINC			05/12/2	011
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L.					
LEDITA C	SE POINTE				HUNTINGTON AVENUE		
HERITAG	SE POINTE			WARKE	EN, IN46792		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL] 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0441		stablish and maintain an					
SS=E		Program designed to provide					
		nd comfortable environment					
		nt the development and					
	transmission of dis	sease and infection.					
	(a) Infection Contr	ol Program					
		establish an Infection Control					
	Program under wh						
	_	ontrols, and prevents					
	infections in the fa						
		procedures, such as					
	isolation, should b	e applied to an individual					
	resident; and						
		cord of incidents and					
	corrective actions	related to infections.					
	(h) Dua cantina Car	and of Infortion					
	(b) Preventing Spr	read of Infection ction Control Program					
	` '	resident needs isolation to					
		d of infection, the facility					
	must isolate the re						
		st prohibit employees with a					
		ease or infected skin					
	lesions from direct	t contact with residents or					
	their food, if direct	contact will transmit the					
	disease.						
	· ·	st require staff to wash their					
		direct resident contact for					
		ng is indicated by accepted					
	professional practi	ice.					
	(c) Linens						
	, , ,	andle, store, process and					
		andic, store, process and a same as to prevent the spread of					
	infection.						
		ations, record reviews,	F04	441	All laundry carts throughout		06/06/2011
	and interviews, the	he facility failed to			facility were observed during		
	ensure infection	control practices were			pass to ensure the carts were properly covered during linen		
followed in a manner to prevent the			pass. All Laundry employees				
		spread of infections and			attended an in-service on De		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155705 05/12/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 801 N HUNTINGTON AVENUE HERITAGE POINTE WARREN, IN46792 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE of Residents Clothing and Linen diseases concerning linen handling for 2 for both Residential and of 2 laundry staff observed (Laundry aide Healthcare on 5/23/11. The #1 and Laundry aide #2) passing personal importance of following the policy linen in 2 of 2 hallways (1A and 2A) for 4 and infection control was reviewed. Failure to follow of 5 linen handling observations, and protocol will result in disciplinary concerning handwashing and glove use action. If a problem should occur, for 6 of 7 nursing staff observed (CNA #'s then it must be brought to the 3, 4, 5, 7, 13, and 14) during personal care attention of either the Laundry and/or Hoyer transfers. This deficiency Supervisor or the Environmental Services Director. Signs have had the potential to impact 101 of 136 been posted in Laundry residents, who were designated as reminding staff to ensure linens incontinent, and to impact 30 of 136 are covered and infection control residents, who utilize the Hoyer lift. policies are followed. The Laundry Supervisor will review (Resident #'s 93, 94, 59, and 60) the delivery procedure weekly for 4 weeks both in Residential and Findings include: Healthcare then quarterly. Any concerns will be reported to the Infection Control Committee and 1. The "DELIVERY OF RESIDENT'S the QA Committee for review and PERSONAL CLOTHES AND LINEN" recommendations. Health Care policy was provided by the Housekeeping Unit; Page 17, Item 5:CNA #3 is a Supervisor. This current policy indicated student nursing assistant (SNA). She was immediately pulled off the following: the floor and retrained. All other SNAs were retrained prior to "HEALTH CARE UNIT providing direct care to residents. Infections of potential residents will continue to be monitored per 1.) Bring both the folding and hanging facility infection control items to the units on the appropriate program. As corrective action for delivery carts. The delivery carts will be Resident #94, CNA #7 was covered. in-serviced on hand washing and pericare with return 2.) Uncover one side at a time as the demonstration of skills to ensure items are removed from the cart....." knowledge of proper care. CNA #7 was given a formal write-up. 2. On 5/9/11 at 12:31 p.m., Laundry Aide CNA #7 reviewed hand washing and perineal care policies with the #1 was observed to be passing personal

Facility ID:

	FOF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155705	(X2) MULTIP A. BUILDING B. WING		00	(X3) DATE: COMPL 05/12/2	ETED
	ROVIDER OR SUPPLIER	.	STREET ADDRESS, CITY, STATE, ZIP CODE 801 N HUNTINGTON AVENUE WARREN, IN46792				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	clothing down the was left uncover continue to enter resident's rooms. observation and opposite side of Aide #2 was also personal hanging room with each of to the sides of the On 5/9/11 at 12:2 interview, Launch tied the cart cover due to the cover cart's wheels and cart. On 5/9/11 at 1:03 was observed to resident's person room to room with uncovered and the tied to the ends of the cart end of the cart lepersonal clothing.	the 2A hallway. The cart ed as Laundry Aide #1 and exit several of the During this same upon entering the the 2A hallway, Laundry to observed passing g clothes from room to end of the cart cover tied the cart. 43 p.m. during an they Aide #2 indicated she ter to the ends of the cart twould get caught in the the would slip off of the 5 p.m., Laundry Aide #2 continue to pass the al hanging clothes from the linen cart the cover ends remained of the cart. 410:10 a.m., Laundry the erved to be passing al clothing down the 2A cart uncovered. The had its ends tied to the aving the resident's			DON. As corrective action for Resident #59, CNA #3, CNA CNA #13, and CNA #14 were in-serviced on hand washing pericare with return demonstration of skills to ensknowledge of proper care. Of #3, CNA #4, CNA #13 and Of #14 were also given a formal write-up. They reviewed hand washing and perineal care policies with the DON. Pleas noted that Resident #60 is not transferred by hoyer lift or has catheter. CNA #5 was in-serfon hand washing and perical with return demonstration of to ensure knowledge of propicare. CNA #5 was given a forwrite-up. CNA #5 reviewed washing, daily catheter care perineal care policies with the DON. The hand washing and sanitizing policy was reviewed use of gloves, standard precautions, perineal care and daily catheter care policies with return demonstration of to ensure knowledge of propicare and to prevent reoccurrence. Hand washing in-services will be conducted with return demonstration of to ensure knowledge of propicare and to prevent reoccurrence. Hand washing in-services will be conducted monthly for 3 months with the annual in-service due in Jun 2011 and then semi-annual. audits will be conducted by watching CNAs provide care Staff not following proper has	#4, re I and sure NA NA I d e ot aviced re skills er I mand ed d ed. or	

000542

´		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155705	B. WIN			05/12/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
LIEDITAC	CE DOINTE			1	HUNTINGTON AVENUE		
	GE POINTE				EN, IN46792		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG			+	IAU	washing or pericare procedu	ıres	DATE
	1	vith the cart uncovered. cart had its ends tied to			will result in disciplinary action		
					Any problems or concerns w	ill be	
		rt leaving the resident's			reported to the QA Committee	ee for	
	personal clothing	dilcovered.			further review and recommendations.		
	5 The WINE OF	CLOVEC CTANDADD			recommendations.		
		GLOVES, STANDARD					
		" policy was provided by					
		n 5/10/11 at 2:00 p.m.					
	This current polic	cy indicated the					
	following:						
	UPROCEDURI	2					
		ng from one surface or					
		vel to another (washing					
		, ,					
		care, perineal care to					
		sident) you MUST					
		inated gloves, wash					
	for the next task.	n clean gloves, as needed					
		nove gloves, and wash					
		ontact with each resident.					
		noroughly wash hands					
	after removing g	ioves					
	The "HANDWA	SHING AND					
		olicy was provided by the					
	1 *	/10/11 at 2:00 p.m. This					
		dicated the following:					
	current policy inc	aicaicu ilic followilig.					
	 "Handwashing	sanitizing will be					
	practiced as follo	_					
	1 ^	after resident contact					
	3. After contact						
		(body fluids, mucous					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155705		A. BUI	LDING	NSTRUCTION 00	(X3) DATE (COMPL 05/12/2	ETED	
		100700	B. WIN		PRESIDENCE CONTROL CON	00/12/2	011
NAME OF	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
HERITA	GE POINTE				EN, IN46792		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	-intact skin, or items that					
	are likely to be c	· ·					
		s and procedures on the					
	same resident to	-					
		tion of different body					
	sites	1 1 0					
	1	e washed after removing					
	1 ^ ~	es. The gloves may have					
	1	and gloves may be					
		ctly, contaminating the					
	hands"						
	6 On 5/0/11 fro	om 11:40 a.m. to 12:10					
	p.m., Resident #						
		the Hoyer lift transfer					
	1 -	CNA #7 removed the					
	1 *	Resident' #94's room and					
	1 ^	the hallway entering					
		oom as she was observed					
	1 * *	r her Hoyer lift transfer.					
	1	g or handgel use was					
	observed.						
	7 On 5/09/11 fr	rom 12:15 p.m. to 12:30					
		59's personal care was					
	1 *	#3 indicated the resident					
		nent of urine. After CNA					
		donned a pair of gloves,					
		ef was partially removed					
		front peri-area care was					
		t, CNA #3 and CNA #4					
	1 ^						
	turned the resident, and as the resident's brief was removed, the resident had been						
		·					
	incontinent of a	large amount of loosely					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155705			LDING	NSTRUCTION 00	(X3) DATE: COMPL 05/12/2	ETED	
	PROVIDER OR SUPPLIEF	!!	1	STREET A	DDRESS, CITY, STATE, ZIP CODE IUNTINGTON AVENUE EN, IN46792	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	the rectal cleaning observed on CN, she indicated she me" and may need gloves." With the completed the resident's brit secured, CNA #3 their gloves. Not use was observed CNA #4 continual back and forth in pants up and post under her in preparts was considered to her glothandgel use was hoyer sling was CNA #3 position hand across her of the Hoyer lift, art transferred to he sling was unhoold CNA #4 and CN CNA #3 then contained took her out handwashing or as CNA #4 remote exited to the soil 8. On 5/9/11 at 3.	ovement (BM). During and of BM, BM was A #3's gloved hands as a was "getting it all over ed to "change places or he same gloves CNA #3 sident's rectal care. After ef was in place and and CNA #4 removed handwashing or handgel d. Next, CNA #3 and ed to turn the resident has bed while pulling her itioning the Hoyer sling paration for her transfer. In a new pair of gloves and device with a wind washing or observed. After the hooked to the Hoyer lift, and the resident's right chest as CNA #4 operated and the resident was are chair. After the Hoyer lift, and the resident was are chair. After the Hoyer lift, and the resident was are chair. After the Hoyer lift, and the resident's hair to the dining room. No handgel use was observed wed the bagged trash and ed utility room. 5:05 p.m., Resident #59's er was observed. With					
	1 110 yer mit trumsit						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OT6011

Facility ID:

000542

If continuation sheet

Page 23 of 28

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155705			LDING	NSTRUCTION 00	CON	TE SURVEY MPLETED 2/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 N HUNTINGTON AVENUE WARREN, IN46792				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	transferred the reher chair. After completed, CNA leave the room w #13 placed the retransported her in room. No handwas observed be after completing 9. On 5/12/11 at interview, ADO one's tasks were handwash before 10. The "RESID CONDITIONS Oprovided by the at 10:30 a.m. Or residents were id or frequently inc The list of reside Hoyer lift, was p #17 on 5/12/11 a residents were id list. 6. The clinical recreviewed on 5/9/1 included but were vascular accident, atrial-ventricular by	with the Hoyer lift as CNA esident's alarm on her and in her chair to the dining washing or handgel use fore exiting the room the Hoyer lift transfer. 8:35 a.m. during an N#12 indicated when completed, one should eleaving the room. DENT CENSUS AND OF RESIDENTS" was Administrator on 5/9/11 he hundred and one entified as occasionally ontinent of bladder. onts, who utilized the rovided by the ADON to 10:15 a.m. Thirty tentified on this current erord of Resident #60 was 1 at 3:40 p.m. Diagnosis not limited to: cerebral hemiplegia, dysphagia,					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	V DIII	LDING	00	COMPL	COMPLETED	
		155705	A. BUILDING B. WING		05/12/2011			
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER			I				
				1	HUNTINGTON AVENUE			
HERITAGE POINTE			WARREN, IN46792					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX			COMPLETION	
TAG				TAG DEFICIENCY)		' ⁻	DATE	
	urinary tract infec	etion.	1					
.	j							
	Resident # 60 was	observed on 5/10/11 at						
		eare, without a previous						
		_						
	incontinent episod	e, with CNA #5.						
	TEL	0 11 1 22						
		ransferred by hoyer lift,						
		sting, to the resident's bed.						
		positioned for pericare with						
	slacks and brief re	moved.						
	CNA #5 washed h	er hands and donned clean						
	gloves. A clean, n	noistened towelette was						
		een the labia, the labia, and						
		ne soiled towelette was then						
	_	garbage container. The						
	_	s also cleaned with a						
	_							
		istened towelette and						
	disposed of in the	garbage container.						
	The CNA did not remove her soiled gloves after cleansing the peri-area.							
	With the same soiled gloves on, the CNA							
	obtained the moisture barrier cream from the							
resident's night stand and applied it between								
	the labia, labia and	d groin of the resident.						
	Ź	-						
	During an intervie	ew on 5/10/11 at 2:00 p.m.,						
	-	ector of Nursing #12,						
		should have changed						
		sing the peri-area and prior						
	to obtaining the m	oisture barrier cream.						
	3.1-18(1)							
	3.1-19(g)							

PRINTED: 06/06/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155705	(X2) MU A. BUII B. WIN	DING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 N HUNTINGTON AVENUE					
HERITA	GE POINTE			WARKE	EN, IN46792			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE	
R0042	annual survey of t state surveyors, a effect with respect subsequent surve Based on observe facility failed to most recent surve the residents for survey books obsthe potential to in Findings include 1. During the en 5/11/2011 at 9:40 housekeeping survey book. The interviewed about survey book. The interviewed about survey book was observed on newspaper rack in the survey book.	e results of the most recent the facility conducted by the my plan of correction in to the facility, and any ys. ation and interview, the have the results of the ey readily available for their review for 2 of 2 served. This practice had impact all residents. : avironmental tour on D.A.M., with the pervisor, the front lobby was observed for the ereceptionist was at the location of the ereceptionist indicated was on the desk behind fice. 1:45 A.M., with the pervisor, a second loose with the survey results the bottom shelf of the entire the library. The entryey book's last survey	R0	042	Please note that there were total of 6 survey books avail in the facility with a sign posthe entrance stating the locatof each book. All residents been identified as being affer should they desire to review survey findings. In addition, survey book at the reception was in fact complete and all books are always updated a same time. It is likely that someone pulled the complais survey dated 9/10/10 from the book in the library. The book the library was updated agas 5/11/11 and all other survey books were checked to ensure they were up-to-date as well survey books were checked ensure they were completed were relocated so that they accessible to residents with having to ask staff for them. signs were posted as to whethe location of the survey recan be found. All survey book will be reviewed monthly for months then quarterly to ensure they are up-to-date. Replacements will be put in books found to have missing survey results. Any concern	able ted at ation have beted the desk t the int hae k in in on ure l. All to and will be but New ere sults bks 3 sure any	05/12/2011	

Facility ID:

PRINTED: 06/06/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155705		(X2) MULTIPLE CO A. BUILDING B. WING	05/12/2011				
NAME OF PROVIDER OR SUPPLIER HERITAGE POINTE			STREET ADDRESS, CITY, STATE, ZIP CODE 801 N HUNTINGTON AVENUE WARREN, IN46792				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	completed on 09/were not posted i	omplaint survey had been /10/2010, but the results n the survey book.		be reported to the QA Comm for review and recommendations.	ittee		
There was no sign posted that indicated where the survey book could be found.							
	worker #6, she in placed the survey	ew with the social adicated the facility had results in the books last ere available for the					
R0154	areas, common diu utensils clean, free and maintained in with 410 IAC 7-24	Il keep all kitchens, kitchen ning areas, equipment, and e from litter and rubbish, good repair in accordance ion, interview and record	R0154	All ice machines in the facilit	y 06/01/2011		
	review the facility sanitary ice machin of 20 residents util	failed to maintain a ne potentially affecting 20 izing that ice machine that floor assisted living area.		were inspected to ensure the were clean, free from litter, rubbish and that they were in good repair. The ice machine located on the third floor ass living unit was immediately	ey n e		
	on the 3rd floor as conducted on 5/10	ellite kitchenette, located sisted living unit, was /11 at 8:10 a.m., with Manager of the Kitchen		cleaned. All other ice machin in the facility were clean and good repair. Dietary staff have been in-serviced on the policicleaning the ice machines. Monthly Cleaning Schedule to clean the ice machines, scool	in ve cy for A to		

000542

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155705	(X2) MULTIPLE C A. BUILDING B. WING	00	l` ´	ESURVEY LETED 2011	
NAME OF PROVIDER OR SUPPLIER HERITAGE POINTE			STREET ADDRESS, CITY, STATE, ZIP CODE 801 N HUNTINGTON AVENUE WARREN, IN46792				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	#15. The ice machine leadinspected with the machine fold up list making apparatus, cubes, was observed substance on it. As used to wipe the specific making apparatus off on the paper to slimy and rust color. The CDM indicate 5/10/11 at 8:40 a.r. recently been work not cleaned after the facility policy 5/11/11 indicated cleanliness and samuachines shall be manufacturer's recently been work and the samuachines shall be manufacturer's recently be samuachines and the samuachines shall be samuachines and the samuachines and the samu	cocated on this unit was CDM present. The ice d was lifted. The inside ice located just above the ice ed to have a rust colored clean paper towel was ubstance from the tus. The substance came owel. The substance was		and trays on a monthly been adopted for the Die employees to follow. The Manager, Assistant Dieta Manager and Shift Supe will ensure compliance to QA checks bi-monthly for months and then quarter concerns will be reported QA Committee for review recommendations.	etary E Dietary Ary Ary Arvisors Arough T 2 Ary I to the		